STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S	ETED	
		15G553	B. WIN			03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE				MERRIL	LVILLE, IN 46410		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
W000000							
			l wo	00000			
	This visit was fo	r a post recertification	""	30000			
		the investigation of					
	•	0122535 completed on					
	01/28/13.						
	Complaint #IN00	0122535: Not Corrected.					
	Dates of Survey and 15, 2013.	: March 11, 12, 13, 14					
	Facility number: Provider number AIM number: 10	:: 15G553					
	Nurse Surveyor I Vickie Kolb, RN Nurse Surveyor I These federal de	ficiencies also reflect					
	9.	accordance with 460 IAC					
	· •	ompleted March 25, 2013 , Medical Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

COMPLETED 03/15/2013					
STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
ON SHOULD BE THE APPROPRIATE COMPI	X5) LETIO ATE				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 2 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G553	B. WING 03/15/2013				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			4TH AVE W		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE				LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W000104	483.410(a)(1)						
		GOVERNING BODY The governing body must exercise general					
		nd operating direction over					
	the facility.						
	Based on record	review and interview, the	W0	00104	Nursing staff was available for	04/12/2013	
	governing body	failed to exercise general			consultation during this period		
	policy and opera	ting direction over the			Since the survey, the agency h		
		ner to ensure 2 of 2			hired two LPNs on staff and ar additional RN to oversee the	1	
	_	elients A and B), and 1			LPNs, to provide medical care	to	
	•	(client C) had nursing			clients. There is an emergency		
	services available to them.				nursing phone in place to be u	sed	
services available to them.		e to them.			in the event that the Nursing s		
	Pinding ind 4.				is not in the office. An RN was		
	Findings include) <u>.</u>			contracted on 1/26/13 to condi- medication administration clas		
	0.004040				and was available for at time of		
		2:00 PM a record review			Nursing Manager's absence if		
		nnel files and nursing			needed. The Nursing Manage		
		of the agency was			was hospitalized from 2/13/13		
	completed. The	records indicated the			2/15/13. During her absence,		
	following:				took phone calls in the hospita just like she does when she is		
					home. Director of Community		
	RN (Registered	Nurse) #1 was hired			Services redistributed		
	01/07/13.				non-nursing portion of job to o	ther	
	RN #1's timecard	d indicated she was not			staff and worked directly with t		
		ing nursing duties or			contracted nurse and temps to		
		F from 02/13/13 after			assure services according to the standards, policies and	IE	
		03/04/13 at 9:00 AM.			procedures. Two LPNs were		
		Practical Nurse) #1's last			hired on 3/11/13. On 4/8/13, a	ın	
	,	· · · · · · · · · · · · · · · · · · ·			RN was hired as Director of		
	day of employment was 01/24/13. LPN #2's last day of employment was				Health Services. One LPN		
	· ·	y of employment was			position remains open with a temporary nurse filling in until	<u> </u>	
	01/24/13. LPN #3's last day of employment was				suitable replacement can be	²	
					found. So at the present time,		
	02/07/13.				The Arc Northwest Indiana		
		an outside provider for	employs two RNs, two LPNs, and				
	contract nursing	services for two LPNs			one temp LPN. All other home	es	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 3 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G553	B. WIN			03/15/2	2013
		_	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1921 54	ITH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	was signed 02/1	8/13.			were affected by this dramatic		
	Contract LPN #	1's first day of service to			change in nursing staff. These		
	the agency was	02/19/13.			new nurses will serve 54 th an	d	
		2's first day of service to			our other group homes. In addition an experienced RN w	ill	
	the agency was	•			stay on staff until such time that		
	life agency was	<i>∨ ⊒₁ ⊒ 11 1 J</i> .			these new nurses are up to sp		
	On 03/12/12 of	11:45 AM an interview			with all of the clients care. We		
		s conducted. The RN			now have a contract with a		
		as hired by the agency			temporary nursing agency so there is no delay in replacing a		
		as currently using the			nurse should one not be able to		
		, ,			fulfill their job duties. In the		
		ntract agency for nursing			absence of the Director of Hea	alth	
	_	with herself. She indicated			Services, the Director of		
		or the agency and was			Community Services was responsible for assuring policion	200	
		ger after hours. She			and procedures and nursing	55	
		ent on sick leave on			services. The Director of Heal	lth	
		as in the hospital 2 - 3			Services is taking on this responsibility and is responsible for future monitoring of nursing		
	days, at which ti	ime she did not have a					
	pager and was n	ot available to the agency					
	for work or calls	s. She indicated the first			services.		
	hours the contra	ct LPN #1 worked was on					
	02/19/13. The F	RN indicated after she was					
	hospitalized she	took beeper call from					
	_	cated she was out of the					
		al leave from 02/13/13 to					
		further indicated there					
		service available to the					
	1	/13/13 to 02/19/13.					
	ugency from 02/	15/15 to 02/17/15.					
	9-3-1(a)						
)-3-1(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 4 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED				
		15G553	B. WING		03/15/2013			
NAME OF F	PROVIDER OR SUPPLIEI	· R		ADDRESS, CITY, STATE, ZIP CODE				
			1921 54TH AVE W MERRILLVILLE, IN 46410					
ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				LLVILLE, IIN 404 IU	(V5)			
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 5 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			TED	
		15G553	B. WIN			03/15/2	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>t</u>		1921 54	1TH AVE W		
ARC OF NORTHWEST INDIANA INC, THE			MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
W000122	483.420 CLIENT PROTECTIONS						
	The facility must ensure that specific client						
	protections requir						
		review and interview, for	W0	00122	Behavioral Health Director will		04/12/2013
		lients (client A), the			review reporting requirements	of	
	•	ticipation: Client			Abuse, Neglect and Exploitation	on	
		not met. The facility			of clients with the Service		
		the rights of all clients by			Coordinator and DSPs and document this review. To mon	itor	
	failing to implen				for continued compliance the		
					Service Coordinator and/or		
	policy/procedure which prohibited client				Community Services Nurse wi		
	_	2 sampled clients (client			observe and monitor all incide		
		failed to provide adequate			reports and daily logs as they	are	
	-	lical care and evaluations			submitted. The Behavior Health Director will		
	regarding client	A's medical condition.			review reporting and investigation		
					requirements for Abuse Neglect, and	d	
	Findings include	:			Exploitation of clients with the		
					Service Coordinator and DSPs that		
	The facility faile	ed to implement their			are involved with 54 th Ave by		
	policy/procedure	which prohibited client			4/25/13. In order to identify other		
	neglect for 1 of 2	2 sampled clients (client			areas of concern all other		
	_	failed to provide adequate			Coordinators will be trained on		
	,	lical care and evaluations			reporting and investigation		
	-	A's medical condition.			requirements for Abuse Neglect, an Exploitation.	u	
					Exploitation.		
	Please refer to W	/149. The facility			In order to prevent reoccurrences		
		lement their neglect			posters explaining client rights and		
		e which prohibits client			reporting requirement will be made		
		•			and distributed to all group homes		
	•	2 sample clients (client			and the day program so that staff		
		neglected to provide			and clients become more aware of		
		rvision and timely			the requirements on an ongoing		
		on for client A after a			basis. Additionally all staff will be		
		edical condition. The			trained on reporting and investigation requirements for		
	facility neglected	d to protect client A from			Abuse Neglect, and Exploitation at		
	injury resulting i	n a foot fracture the			Abuse Neglect, and Exploitation at		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 6 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 03/15/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	I '		least annually unless changes occur or need requires this to be done more frequently. To ensure that Service Coordinator are trained on reporting and investigation requirements for Abuse Neglect, and Exploitation the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review been training at least annual and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation prior to working a home or with a client. In addition, the Service Coordinators will be present in the homes at least two times per mon to ensure protection of clients, address concerns, monitor activitie etc. Documentation of visits will be completed and will include specific to the client as well as the visit. The Behavioral health Director will review progress notes regularly.	DATE DATE DATE DATE DATE DATE DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 7 of 61

NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (LIACH IDERICANCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (LIACH IDERICANCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (LIACH IDERICANCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (LIACH IDERICANCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (LIACH IDERICANCY MILEST BLE PRECIDED BY PILL) ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCY MILEST BY A SUMMARY STATEMENT BY A SUMMARY STATEMENT BY A SUMMA	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAMI OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISE INSECTION INSTEAM PRETIX TAG REGULATORY OR LISE INSECTION INFORMATION) W000149 433 420(0)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedure review and interview for 2 of 3 BDDs (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDs (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDs report dated 02/26/13 indicated: "(Client A) had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	DING	00	COMPLETED	
ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DESCRICTES TAGE REGILATORY OR IS C IDENTIFYING PROJECTION. W000149 483.420(g(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement wither policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BIDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted			15G553			-	03/15/2013	
ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREITX (RACH DIFFICENCY MUST BE PRECEDED BY UPLL TAG REGULATORY OLE SUBMITTY NOR PRECEDED BY UPLL TAG REGULATORY OLE SUBMITTY NOR PRECEDED BY UPLL TAG REGULATORY OLE SUBMITTY NOR CHENTEN TAG W000149 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedure that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BIDDS (Bureau of Developmental) Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting/falling to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to protect client A from injury resulting in a foot fracture the agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted				1		ADDRESS, CITY, STATE, ZIP CODE		
NAS D PREFIX CRACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CRACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PRECEDENCY MUST BE PRECEDED BY FULL TAG PRECEDENCY MUST BE PRECEDED BY FULL BE PRECEDED BY FULL BY FU	NAME OF P	ROVIDER OR SUPPLIER			1921 54	1TH AVE W		
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) W000149 483 A20(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to provide timely medical care/reatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted PREFIX TAG PREFIX TAG TAG COMPLETION CROSS-BERREACCED TO the APPROPRIATE CROSS-BEFERRACED TO The APPROPRIATE CROSS-BEFERRACED TO THE APPROPRIATE TAG COMPLETION CROSS-BEFERRACED TO THE APPROPRIATE TAG COMPLETION CROSS-BEFERRACED TO THE APPROPRIATE TAG COMPLETION CROSS-BEFERRACED TO THE APPROPRIATE TAG PREFIX TAG TAG PREFIX TAG TAG CROSS-BEFERRACED TO THE APPROPRIATE TAG COMPLETION CROSS-BEFERRACED TO THE APPROPRIATE PREFIX TAG TAG PREFIX TAG PREFIX TAG TAG BEANDORY (PAPPOPRIATE Behavioral Health Director will review reporting requirements of Abuse, Neglect and Exploitation of Clients with the Service Coordinator and Or Community Services Nurse will review adout and occument will review adout and occument and service Coordinator and/or Community Services Nurse will review and proporting requirements of Abuse, Neglect and Exploitation of clients with the Service Coordinator and/or C	ARC OF NORTHWEST INDIANA INC, THE			MERRII	LLVILLE, IN 46410			
## RECHATORY OR LSC IDENTIFYING INFORMATION) ## 483.420(d)(1) ## 5TAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. ## Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to protect client A from injury resulting in a foot fracture the agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. ### Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted #### CROSS REFERRACED TO THE APPROPRIATE DOCATION AND APPROPRIATE DATA AND ASSISTANCE TO ASSISTANCE TO ASSISTANCE TO ASSISTANCE TO ADMITS AND APPROPRIATE TO ASSISTANCE TO APPROPRIATE TO APPROPRIATE TO ASSISTANCE TO APPROPRIATE TO APP	` ′							
W000149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to protect client A from injury resulting in a foot fracture the agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted W000149 Behavioral Health Director will review reporting requirements of Abuse, Neglect and Exploitation of clients with the Service Coordinator and DSPs and document this review. To monitor for continued and comment this review. To monitor of continued and comment with the Service Coordinator and/or Community Services Nurse will review and monitor at least monthly. Service Coordinator and/or Community Services Nurse will review and monitor at least monthly. Service Coordinator and/or Community Services Nurse will review and monitor at least monthly. Service Coordinator and/or Community Services Nurse will review and monitor at least monthly. Service Coordinator and/or Community Services Nurse will review and monitor at least monthly. To monitor for continued compliance the GMRP or Community Services Nurse will review daily logs daily, and document any issues in clients' medical file.		`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to protect client A from injury resulting in a foot fracture the agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted W000149 Behavioral Health Director will review reporting requirements of Abuse, Neglect and Exploitation of clients with the Service Coordinator and DSPs and document this review. To monitor for continued compliance the Service Coordinator and/or Community Services Nurse will retrain all staff for all medical supervision with regards to immediately identifying and reporting in a timely manner any change in consumer's appearance. To monitor for continued compliance the QMRP or Community Services Nurse will retview daily logg daily, and document any issues in clients' medical file.			LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
determine a diagnosis. [Client A]		483.420(d)(1) STAFF TREATMI The facility must of written policies are mistreatment, neg Based on record 2 of 3 BDDS (Br. Disabilities Serve client protection, implement the far procedure prohibin neglecting/failing supervision to 1 (client A), neglecting from injury result agency could not provide timely mevaluation of injury problems to her pain problems. Findings include On 03/11/13 at 2 of the BDDS (Br. Disabilities Serve completed and in 1. A BDDS repointment to sincurologist at [he physical change. [client A] to perfect the server of the property of the property of the provide timely mevaluation of injury problems.	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. review and interview for ureau of Developmental ices) reports regarding the facility neglected to acility's policy and biting client neglect by g to provide appropriate of 2 sample clients acted to protect client A liting in a foot fracture the at explain, neglected to nedical care/treatment for arry and unknown medical left side and right foot E::15 PM a record review areau of Developmental ices) reports was adicated the following: Ort dated 02/26/13 and an and ee Dr (doctor) [name], a a ospital name] due to Dr [name] admitted form a series of tests to	W0		Behavioral Health Director will review reporting requirements Abuse, Neglect and Exploitatio of clients with the Service Coordinator and DSPs and document this review. To mon for continued compliance the Service Coordinator and/or Community Services Nurse wi observe and monitor at least monthly. Service Coordinator and/or Community Services Nurse wi retrain all staff for all medical supervision with regards to immediately identifying and reporting in a timely manner at change in consumer's appearance. To monitor for continued compliance the QMRP or Community Services Nurse wi review daily logs daily, and document any issues in clients	of on itor II	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 8 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN			03/15/2013	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ITH AVE W		
ARC OF NORTHWEST INDIANA INC, THE			MERRII	LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY		DATE
	remains in the hospital. [Client A] seems to be in fair condition."						
	2 A DDDC ****	out dated 02/05/12					
	_	ort dated 03/05/13					
		Service Coordinator (SC)					
		where [client A] is being					
	_	tatus update. The nurse rvice Coordinator that					
	1 2	nosis was multiple right are 2nd, 3rd, and 4th toes.					
		nformed me (SC) that					
		. ,					
		foot has a mild fracture."					
		"[Client A] does remain					
		t this time. The nurse					
		treatment that the doctor					
	_	ce a boot on [client A's]					
	_	r her a mobilization					
		to walk and for the right					
		o heal on its own. An					
	_	s been initiated for					
	unknown origin.						
	The Investigation	n Fact Sheet Summary for					
		•					
		ident and Conclusion					
		ndicated: "All staff at					
		gency's own day program)					
		at group home reports no					
		sion toward client. There					
	_	ort at Day Services that					
		's (A's) foot were noticed,					
		oticed signs but it was					
	I -	f that there were problems					
		e per Developmental					
	Specialist who d	lenies informing staff of	\perp				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 9 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G553			LDING	NSTRUCTION 00	(X3) DATE COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER		p. WIIV	STREET A 1921 54	DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	client's foot, reports service Coordination incident report. foot & additional the client left how 02/25/13, but be from Day Service Conclusion: "It A] sustained her on 02/25/13, how injuries CANNO failed to report services Safety Tech & many consumer was depain by pointing Recommendation training on recognition of the client pointer realized somethins its most of day at the Investigation contained Intervestatements taken worked with cliestatements contained information: 03/05/13: Day Swrote, "Most of [client A] was we times throughout	is my belief that [client injuries at Day Service vever, the cause of the off be determined. Staff igns of injury to Health & nanagement when emonstrating signs of to foot on 02/25/13." Ins: "Staff will be given gnizing signs of injury. End at foot and no one ong was wrong. Client at workshop." In dated 03/08/13 iew Fact Sheets of of the staff who had					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 10 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G553	B. WIN	G		03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITH AVE W		
ARC OF NORTHWEST INDIANA INC, THE				MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE
	"	r because she was most					
		. The last day I saw					
		hen she went on her					
	doctor's appointr	nent"					
		aff #1 wrote, "Last time I					
		as about a week & half					
	` / • `	't remember the exact					
		problem I noticed, was					
		the bathroom more on					
	herself. Staff rep	ported that to the Health					
	& Safety Tech						
	03/08/13: DS sta	aff #1's addendum					
	indicated, "1. St	aff (unidentified) said					
	that [client A] w	as using the bathroom on					
	herself, but they	told [name] the Health &					
	Safety Tech. Th	e staff that work with					
	1	ed the peeing [urinating]					
		& Safety Tech. 2. The					
		Tech noticed that she					
	1	r left side, and said that					
	she is going to ca	*					
		d find out why she wasn't					
		e. No I did not tell a staff					
	~	vas going on with her left					
	I -	a & Safety Tech was the					
		[client A] not using left					
		ff will notify the Health					
		Ethere are changes in					
	1	injuries8. I don't know					
		out her left side. 9. I					
		p hab (habilitation), I					
		I go between all day,					
	attend meetings,	I am not in one room all					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 11 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G553	B. WIN	G		03/15/2013	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			TH AVE W		
ARC OF NORTHWEST INDIANA INC, THE				MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG	day. I bounce between four different			TAG	BETTELLINETY	DATE	
	*	my responsibility to					
	(sic) to"	lo what they are suppost					
	(SIC) to						
	03/06/13: Heath	& Safety Tech (HST)					
		notice that [client A] was					
	·	ut was concern (sic) that					
		g on herself, which is not					
	[client A]"	5 on nersen, which is not					
		Addendum indicated, "					
		nator] said she has an					
		go to the doctor on					
	^^	26/12) and [staff #3] ask					
	l • `	ipt (order) from the					
	doctor for a UTI	(Urinary Tract Infection)					
	and I said no but	I was concern (sic). As					
	for documenting	or writing an incident					
	report, I blame n	nyself for not writing one.					
	I just want (sic)	to see if I can get the care					
	done for her righ	t away. No one told me					
	that [client A] w	as pointing at her feet"					
		4 wrote, "last time I					
	` ′ ′	client A] was Monday					
		notice (sic) something					
	_	her. She didn't wanna					
	_	e bathroom. Staff ask					
		what was going on, she					
	-] some one said that she					
		using her left side. So					
		h her I'll put her and (sic)					
		we both wouldn't fall					
	(sic). This has b	een going on I think for 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 12 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
MOLLAN	OI COMMENTON	15G553		LDING		03/15/	
		.0000	B. WIN		ADDRESS CITY STATE ZID CORE	33, 13,	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)		DATE
		riced something was					
		er because she kept using					
		herself. Friday or					
	- ·	13 or 02/25/13) [client A] ing (sic) her feet (sic)					
		there I saw that she was					
	_	socks was to to (sic). I					
		vas walking funny. [DS					
	` ′	nething was going on					
		e[client A] gets drop					
		c) up by home staff"					
	(sic) and pick (si	c) up by nome starr					
	03/06/13: Group	Home (GH) staff #1					
	wrote, "Monda	y morning (02/25/13) she					
	(client A) left for	r workshop (day service),					
	she was walking	her normal unsteady gait					
	and when I picke	ed her up the staff at the					
	workshop broug	ht her out in a wheelchair					
	and when I stood	l her up to walk to the					
	van she was limp	oing on her left foot.					
	When she got ba	ck to the group home I					
	assisted her into	the house. I let her go to					
	close the door ar	nd she attempted to walk					
	and fell with the	first step. I helped her					
	up and sat her do	own in a chair an took					
	(sic) off her coat	and shoes. She sat and					
	did not move un	til dinnertime when I					
	stood her up and	as soon as she stepped					
	on her left foot s	he fell again. I helped					
	her up to the din	ner table so she could eat					
	then I called the	service coordinator to ask					
	her if it had been	reported that she fell at					
	the workshop tha	at morning and she said					
	no. She (SC) tol	d me to do an incident					
	•						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 13 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G553	B. WIN			03/15/	2013
NAME OF F	PROVIDER OR SUPPLIER	L.			DDRESS, CITY, STATE, ZIP CODE TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
TAG		falls and that she would		TAG	BEHELEN,		DATE
	check on it the n						
		nd that [client A] had an					
	_	next day and she would					
		check her out. Also					
		llen once prior to this					
		er. When things happen					
		(day service) there is no					
	· •	between the group home					
		to what happens and					
	_	and what the end result					
	isDuring the w	reek when she is at home					
	she rarely has an	y accidents on herself					
	except at night w	when she is asleep at					
	night. Workshop	p staff says that she has					
	an accident just	about everyday on					
	herself. Wen I p	picked her up (sic) at the					
	workshop on Fel	b. 25, 2013 the staff that					
	_	said that [client A] had an					
		elf and that she kept					
	~ ~	shoe. When I put her to					
		ht (02/25/13) her left foot					
	•	when we were at the					
		3) and I was getting her					
		ced bruises on the bottom					
		ad them do an x-ray and					
	-	found it to be broken or					
		her left foot. I honestly					
		ever happened it happened					
		On Monday night					
		I put her to bed I looked					
		appeared to be fine but					
		ertain places like the ball vould snatch her foot					
	of her foot sne w	ourd Shatch her 100t					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 14 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G553	B. WIN	G		03/15/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					ITH AVE W	
ARC OF	NORTHWEST IND	ANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	away from me."	1. 11.1				
		ed to call the nurse on				
		m her of the falls, or				
	_	e in status, from when she				
		ning of 02/25/13, to when				
		from day service on				
	02/25/13 in the I	PM.				
	03/06/13: Servi	ce Coordinator written				
		ted, "I contacted [HST].				
		me that she has not been				
		ny staff that [client A]				
		lid state that when it's				
		ion, [client A] refuses to				
		gets (sic) a wheelchair				
		take her medication"				
	_	ddendum indicated, "The				
		tment was made due to				
		Wanted to get her				
		ause she was having				
		ng left hand & urinating				
	` ′	·				
		fusing to do anything.				
		ay Services wanted a UTI [client A] kept urinating				
	-	vice. [HST] was the				
	1 * *	g the cup, but never did				
		octor's appointment.				
		lent Report stating this				
	information."					
	An Incident/Acc	ident Report dated				
		ned at 4:50 PM and 7:45				
		H staff #1 indicated,				
		oing when I picked her up				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 15 of 61

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S	
		15G553	A. BUII B. WIN	LDING G		03/15/	2013
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		op and when we got to					
	,	she was not putting any					
	_	ft foot and fell when she					
	1	sterday evening." The					
		he questions, "What did					
	1 *	s Incident/Accident?"					
		te, "called the service					
		did an incident report."					
		not contact the nurse to					
	_	lls or client A's inability					
	to bear weight or	n her left foot.					
	03/12/13 at 10:5 (Individual Suppindicated she was a fall risk plan. "Contact the Ninstructions ever occurred" Clithe following da 02/07/13: Cumuindicated, "Rece	n if unsure an injury has ent A's record contained ted documents: alative Medical Record ived report from day					
	a couple (sic) tin test) being done. by LPN #2 on he employment. The 02/21/13 and income refused neuro (n	ent A] urinated on herself nes yesterday. U/A (urine " The entry was signed er last day of ne next entry was dated licated, "[Client A] eurology) follow-up ay. Rescheduled for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 16 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN	G		03/15/2	013
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1921 54	TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		from MD (Medical					
	·	alysis with C & S					
	*	itivity) if indicated. Dx					
	(diagnosis) UTI	(Urinary Tract Infection).					
	02/12/12: Order	from client A's MD					
		results (UA) was,					
		. , ,					
	"Abnormal but n	•					
		ns: Push p.o. (oral) fluids					
	1	id restriction." Client A's					
		dicate the nurse reviewed					
		ried out this order. The					
		I no documentation by a					
	nurse related to t	this order.					
	02/26/13· Cumu	ılative Medical Record					
		itted to [hospital]."					
	maicateu, Aum	itted to [nospitar].					
	The Hospital Re	cord contained the					
	following docum	nented information:					
	_						
	02/26/13: X-Ra	y - Foot/complete -					
	Impression: No	ndisplaced fractures					
	involving the bas	ses of the second, third					
	and fourth metat	arsals. There is mild					
		fracture fragments."					
	_	-					
	02/27/13: Histor	ry and Physical indicated,					
	"This is a patient	t I saw yesterday in my					
	_	o the emergency room					
		ent's caregiver told me					
	_	ing some problems					
		alking. She was also					
		at weak on the left side,					
	Teening somewha	it weak on the left side,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 17 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G553	B. WINC			03/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	SR .		1921 54	ITH AVE W		
	NORTHWEST IN	DIANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		itted for further					
		e patient was admitted for					
		on and now the patient					
	_	have left ankle fracture on					
		ankle, which was a					
	nondisplaced fr	acture involving the base					
	of the second, t	hird, and fourth					
	metatarsals. Th	nere is mild impaction of					
	the fracture frag	gment also. The patient is					
	admitted for fur	rther					
	evaluationIm	pression: This is a					
		as several problems: 1. A					
	^	re. 2. Left-sided					
		ould be a stroke versus					
		erative joint disease related.					
	_	on: My recommendation					
		MRI (Magnetic					
		` •					
		ging) of the brain and					
	-	and then for the ankle					
	-	ient is going to be seen by					
	an orthopedic d	octor."					
		atry Consult Note: "This					
		e with non displaced					
		left footThe 2nd					
	metatarsal appe	ears to be impacted at the					
	fracture site and	d it is non displaced. It is					
	an unstable frac	cture but will do well					
	conservatively	if the patient is non weight					
	bearing for 6-8						
	03/03/13 - PT (Physical Therapy)					
	Evaluation indi	cated client A was bed					
	ridden and weig	ght bearing status was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 18 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER		•	1921 54	ADDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	indicated follow- "Other Goal: To ROM (Range of Extremities). To positioning to pr development" 03/04/13: Rehab Evaluation/Pread Rehab Admissio Illness: "admit possible new CV Accident) (stroke patient to the em was evaluated, n fullness leg eryth with some swelli was unremarkab that right (sic) fo demonstrated so the metatarsals. admitted for TIA Attach) (loss of I brain) rule out C to me for rehabil further rehabilita because the patie to walk and not a livingThis pati admission criteri with family. The	Imission Screening For n: "History of Present ted on 02/26/13 for 'A (Cerebrovascular e). He referred the ergency room where she oted to have right nema (redness of the skin) and but had neuro exam le. She had an x-ray of tot (left) area that me multiple fracture of She was however a (Transient Ischemic blood flow to a part of the VAPatient was referred itation evaluation and the total management ent was weak and not able able to do activity of daily tent does not meet rehab a. Discharge plan: home to patient requires:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 19 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 03/15/	
		15G553	B. WIN			03/15/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	IANIA INC. THE			ITH AVE W LLVILLE, IN 46410		
					LEVILLE, III 404 IU	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1110	REGUERTORT OR	ESC IDENTIFICATION OR METHOD,		1710			DATE
	02/06/12: Disab	arge Summary: "Admit					
		Admitting Diagnosis:					
		harge Diagnosis: Multiple					
		al (toe) fractures.					
	` ′	urse in Hospital With					
		f Any: Pt (patient) was					
	•	hopedic consultation					
		nmendations carried out.					
	ĺ .	legible] and now has					
	-	obilization device to her					
		be dc (discharged) with					
	home health PT/	` ,					
		tional Therapy) at home.					
	Disposition: DC	* * *					
	_	6/13." Client A was					
	_	a prescription order from					
	_	ring PT/OT therapy. The					
	hospital faxed th						
	-	ch indicated, "will need					
		s. Staff to transport at					
	6:00 PM."	. Starr to transport at					
	0.00 I IVI.						
	03/06/13· Cumi	lative Medical Record					
		narged from [hospital].					
	Returned to grou						
	Returned to grot	ip nome.					
	 03/07/13: Cumi	lative Medical Record					
		act nurse indicated,					
	_	at group home to assess					
		• •					
	patientPain noted to bilat (bilateral) (both) feetBoot applied to L (left).						
	Assist with transfers by DSP (Direct						
		N.O. (New Order) for					
	Support Starr)	11.0. (110 W Older) IUI					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 20 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
1111212111	or conditions	15G553	A. BUII			03/15/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ITH AVE W		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DIA TELENCTY		DATE
	PT/OT Therapy.						
	On 02/11/12 of 2	20 DM a marriagy of the					
		2:30 PM, a review of the 2 Policy For Handling					
	1	t and Abuse indicated,					
		nwest Indiana prohibits					
		t and exploitation of our					
		Il immediately report any					
	allegations of ab						
	~	ur clients per agency					
	_	ure. The ARC Northwest					
		et current regulatory					
		reporting all incidents.					
	All allegations o						
	_	xploitation will be					
		The ARC Northwest					
		gation process while					
	l '	dividualNeglect - is					
		e to consider and provide					
	for the safety or	care of the client and					
	anticipate and re	medy the placing of a					
	client in a situati	on that poses a threat to					
	his/her health an	d well-being. Examples					
	include, but are i	not limited to, depriving a					
	client of food, dr	rink, clothing, sleep,					
	shelter, use of ba	throom facilities, or					
	medical care/trea	ntment, seclusion by					
		dual alone in a room or					
		which exit is prevented;					
		equate personal care,					
	_	nsupervised, etcall					
		within ARC Bridges,					
	`	RC Northwest Indiana)					
	services will be t	treated as suspected					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 21 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	A. BUII	LDING	00	COMPL 03/15/	ETED
		10000	B. WIN		DDDEGG OUTV CTATE ZID CODE	00/10/	20.0
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	_	d investigations will be					
		nal investigation refers to					
		an be successfully					
		the department (Possible					
	-	e a staff person accused					
	_	t a name or an injury of					
	_	that can be traced to an					
	incident documer	-					
		vestigations should					
		procedures with regards					
		distribution. Because					
		orted to all the State					
	_	discussed with the					
		Director or designee,					
	there is no chance	•					
		s of unknown origin are					
		gation of abuse or					
	neglect."						
	An interview wit	h the RN (Registered					
		ucted on 03/13/13 at					
	·	RN indicated staff should					
		ne nurse when the client					
		02/25/13 when she was					
		ther indicated there were					
		nts that night which					
		ted the staff to call the					
		ated staff were to contact					
		he client has a change of					
		had a change of status					
		home limping after day					
		e fell twice, when she					
		veight on her foot and					
		her foot away when staff					
	when she puneu	nor root away when starr					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 22 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE (COMPL		
ANDILAN	OF CORRECTION	15G553		LDING	00	03/15/	
		130333	B. WIN			03/13/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		RN indicated day service					
		e reported the problems					
		eft side to the nurse as it					
		e might have had a					
	stroke. She indi	cated staff did not have to					
	know what was	wrong with the clients,					
	-	ply report a change. Day					
	service and grou	p home staff neglected to					
	report those char	nges. The RN indicated					
	the nurse who sa	w client A in the group					
	home the day aft	er she was discharged					
	failed to define h	now staff were to transfer					
	client A or to ob	tain orders on how to					
	transfer client A	safely with her fractures.					
	There were no in	structions for staff					
	regarding client	A's care regarding					
	bathing, toileting	g, bed or transfers from					
	one place to anot	ther. The nurse neglected					
	_	A's needs were met by					
	obtaining PT/OT	Therapy. The RN					
	indicated staff fa	iled to follow the facility					
	policy and proce	dure on abuse and					
	neglect when the	ey neglected to report					
	_	ion on 02/25/13. The RN					
	indicated based	on the information					
	surrounding the	facts on 02/25/13, client					
	_	een seen by a medical					
		ay and should not have					
	*	heduled appointment the					
	next day.	11					
	- · · ··· <i>y</i> ·						
	9-3-2(a)						
	()						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 23 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553			(X2) MULT A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE COMPL 03/15/	ETED
	PROVIDER OR SUPPLIE		S' 1	921 54	ODDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 24 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		A. BUILDING B. WING			COMPLETED 03/15/2013		
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TH AVE W		
ARC OF I	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON SHOULD BE COMPLETION	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000192	Based on observations at the conducted on 03/4 until 6:45 PM. Obe pushed by station a wheelchair.	ation, record review and exted toward clients' health exted toward clients he group home were /11/13 from 4:30 PM client A was observed to ff #3 into the group home Client A was assisted	Woo		The Community Service Nurse has trained DSPs on proper transfer methods(non weight bearing body repositioning) for client A. Staff has been trained client's risk plans, as well as assessing for pain. To ensure further compliance to Community Services Nurse and/or Service Coordinator will visit group home weekly for the months and at least bi-monthly thereafter to monitor risk plan implementation.	e d on the I	
	each side and she	aff #2 and staff #3) to e stood on her left foot her towards the couch					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 25 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G553	B. WIN	G		03/15/2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					ITH AVE W	
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		on the couch. The				
	1 '	ff #2 and #3 verbal				
		ow to transfer the client				
		hair to the couch using				
		ent, "How to Perform a				
	Two-Person Tra					
		lient A sat on the couch				
		sisted by staff #2 and staff				
	#3 to stand up, b	earing weight on her				
		ne sat down in the				
	wheelchair and v	was wheeled to the				
	kitchen table for	supper.				
	Staff #2 was inte	erviewed on 03/11/13 at				
	4:20 PM. She in	dicated she had not				
	worked at this ho	ouse for awhile and was				
	not the usual star	ff. She indicated she had				
	not worked with	client A since she had				
	returned home fr	om the hospital with the				
	boot immobilize	r (for her foot fracture)				
	on her left leg.	,				
	Staff #3 was int	erviewed on 03/11/13 at				
		idicated she was not the				
		home and she usually				
		to medical appointments.				
		e had not worked with				
		e had returned home				
	from the hospita					
	immobilizer on l					
	ininioonizei on i	ioi ioit iog.				
	A record review	was conducted on				
		PM, of the undated,				
		n a Two-Person Transfer				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 26 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	A. BUILDING 00			COMPLETED 03/15/2013	
		10000	B. WIN			00/10/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		air" gave the following					
		rforming a two-person					
		heelchair can be a tricky					
	_	re people helping, the					
	better, although t	wo is a safe					
	minimumHold	the person under her					
		ing next to her. Left the					
	person using you	legs, not your back.					
	When you have t	ransferred the weight					
	from the wheelch	nair to yourself, move the					
	chair out of the w	vay. If you have					
	someone helping	you, they can do this					
	tasktwist round	to transfer the person					
	onto or into the o	bject they are being					
	moved to" Th	e document did not					
	indicate what per	rson #1 or person #2 were					
	-	. The document failed to					
	-	t should not bear weight.					
		Č					
	The QMRP (Qua	lified Mental					
		essional) was interviewed					
		6 PM. The QMRP					
		se had seen client A in					
		after she was discharged					
	_	. She indicated the nurse					
	_	instructions on how					
	_	sfer and care for client A					
		She indicated the					
		I discharge information					
	_	ny information for					
	transfers either.						
	left foot had fract	ion indicated client A's					
	immobilized by a	a boot immobilizer. She					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 27 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	A. BUI	LDING	00	COMPLETED 03/15/2013	
		130333	B. WIN			03/13/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		l been contacted by the					
		discharge and the					
	•	d client A had fractures					
		nd right sides and was					
	_	nt to promote healing.					
	She indicated clie						
	` •	l Therapy) and PT					
	(Physical Therap	y) appointments after					
	discharge and the	e nurse had not arranged					
	those yet. She in	dicated she received no					
	written instruction	ons/training from anyone					
	on how client A	should be transferred,					
	bathed or toileted	d and she developed a					
	written "How to	Perform a Two-Person					
	Transfer From a	Wheelchair" after					
	watching a video	given to her by the					
	_	department since no					
	written policy/pr	-					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	This federal tag r	relates to complaint					
	#IN00122535.						
	This deficiency v	was cited on 01/28/2013.					
	The facility failed	d to implement a					
	systemic plan of	correction to prevent					
	recurrence.						
	9-3-3(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 28 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CC A. BUILDING B. WING	00					
ARC OF	PROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410						
	NORTHWEST IND SUMMARY S (EACH DEFICIEN				SHOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 29 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G553		(X2) MU A. BUIL B. WING	DING	onstruction 00	(X3) DATE S COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ITH AVE W LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000210	Has.440(c)(3) INDIVIDUAL PROWithin 30 days af interdisciplinary to assessments or not of supplement the conducted prior to supplement the cond	pogram PLAN ter admission, the team must perform accurate teassessments as needed to preliminary evaluation to admission. ation, record review and cility failed to assess the team weight bearing ther body) of client A in DLs/activities of daily dressing, toileting) after a sysical status/foot 2 sampled clients (client	Woo	00210	Upon discharge from hospital IDT will meet within 30 days to assess changes in programmi and medical treatment. To ensure future compliance a changes in client condition will evaluated by the team or the appropriate professional base on the presenting change with days of knowledge.	ng any be	04/12/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 30 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN	G		03/15/	2013
NAME OF F	PROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		n on the couch. The					
		ed Mental Retardation					
	, , ,	ve staff #2 and #3 verbal					
		now to transfer the client					
		hair to the couch using					
		ed document, "How to					
	Perform a Two-	Person Transfer From a					
	Wheelchair." C	lient A sat on the couch					
	until she was ass	sisted by staff #2 and staff					
	#3 to stand up, b	earing weight on her					
	right foot and sa	t down in the wheelchair					
	and was wheeled	d to the kitchen table for					
	supper.						
	Staff #2 was inte	erviewed on 03/11/13 at					
		ndicated she had not					
		ouse for awhile and was					
		ff. She indicated she had					
		client A since she had					
		rom the hospital with the					
		er (for the foot fractures)					
	on her left leg.	if (for the foot fractures)					
	on nor left leg.						
	Staff #3 was int	terviewed on 03/11/13 at					
		ndicated she was not the					
		home and she usually					
		s to medical appointments.					
		e had not worked with					
		ne had returned home					
	from the hospita						
	immobilizer on l	ner left leg.					
	A record review	was conducted on					
	03/11/13 at 5:30	PM, of the undated,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 31 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G553 A. BUILDING A. BUILDING			COMPLETED 03/15/2013			
		100000	B. WIN			03/13/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		n a Two-Person Transfer					
		air" which gave the					
		etions: "Performing a					
	-	fer from a wheelchair can					
		ssThe more people					
	helping, the bette	er, although two is a safe					
		the person under her					
	arms while stand	ing next to her. Left the					
	person using you	legs, not your back.					
	When you have t	ransferred the weight					
	from the wheelch	nair to yourself, move the					
	chair out of the v	vay. If you have					
	someone helping	you, they can do this					
	tasktwist round	I to transfer the person					
	onto or into the o	object they are being					
		e document did not					
	indicate what per	rson #1 or person #2 were					
	_	o. The document failed to					
		t should not bear weight.					
		_					
	The QMRP (Qua						
		essional) was interviewed					
		6 PM. The QMRP					
		se had seen client A in					
		after she was discharged					
	from the hospital	l. She indicated client A					
	was hospitalized	from 02/26/13 and					
	discharged 03/06	5/13. She indicated the					
	nurse did not lea	ve any instructions on					
	how staff were to	transfer and care for					
	client A and her	fractures. She indicated					
	the 03/06/13 hos	pital discharge					
	information did r	-					
		ransfers either. She					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 32 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/15/	ETED
	PROVIDER OR SUPPLIER		p. WIIV	STREET A 1921 54	.DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	hospital prior to hospital indicate on both the left a not to bear weigh needed OT and I discharge (for accessive to leave the position to	n anyone on how client A erred (moved from ion) safely, bathed or developed a written in a Two-Person Transfer air" after watching a er by the agency training e no written					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 33 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 15/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	9-3-4(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 34 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/15/2013	
	ROVIDER OR SUPPLIER			1921 54	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000318	_	BERVICES ensure that specific health uirements are met.	WO	00318	Community Service Nurse will address all medical issues in regards to clients needs. To ensure future compliance Community Service Nurse will observe and assess all medicissues that are brought to the attention as needed on an ongoing. An RN was contracted on 1/26/13 conduct medication administration classes and was available for at time of Nursing Manager's absence if needed. The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, she took phone calls in the hospital just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to other staff and worked directly with the contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, an R was hired as Director of Health Services. One LPN position remain open with a temporary nurse filling in until a suitable replacement can be found. So at the present time, The Arc Northwest Indiana employ two RNs, two LPNs, and one temp LPN. All other homes were affected by	ll call ir to lee s	04/12/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 35 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/15/2013			
ARC OF	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
			this dramatic change in nursing staff. These new nurses will serve th and our other group homes. In addition an experienced RN will stron staff until such time that these new nurses are up to speed with a of the clients care. We now have a contract with a temporary nursing agency so that there is no delay in replacing a nur should one not be able to fulfill the job duties. In the absence of the Director of Community Services was responsit for assuring policies and procedure and nursing services. The Director Health Services is taking on this responsibility and is responsible for future monitoring of nursing services. When a consumer is hospitalized to Community Services Nurse in coordination with the Service Coordinator will develop plans to address any changes in condition. meeting will be held within 24 hou prior to or following discharge with the day program and others relevate to the client's care and document team discussion and approvals if necessary. To prevent reoccurrent this will be done for all consumers returning home after hospitalizations a standard practice.	ay II se eair ole ess of r he A ars and ant ce,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 36 of 61

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET	TED
A. BUILDING	
15G553 — — — — 03/15/20	:013
B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1921 54TH AVE W	
ARC OF NORTHWEST INDIANA INC, THE MERRILLVILLE, IN 46410	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	DATE
The Behavior Health Director or the	
Community Services Operations	
Director will hold a weekly meeting	
to review changes in client status	
and ensure these meetings are	
scheduled or have been completed	
and document this discussion.	
Based on observation, record review and	
interview, the Condition of Participation:	
Health Care Services was not met. The	
facility failed to ensure adequate health	
care services were available for 1 of 2	
sampled clients (client A). The facility	
failed to ensure their nursing services	
were available to train direct care staff,	
secure evaluations, write methodologies,	
implement doctor's orders and supervise	
medication administration so as to assure	
client A received timely health care	
services for her condition after a change	
in her physical status/fractures.	
Findings include:	
The facility failed to ensure their nursing	
services were available to train direct care	
staff, secure evaluations	
(Occupational/Physical Therapy), write	
methodologies, implement doctor's orders	
and supervise medication administration	
so as to assure client A received timely	
health care services after a change in her	
physical status/fractures.	
1. Please refer to W192 as the facility's	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 37 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G553		(X2) MULTIF A. BUILDING B. WING		00	(X3) DATE COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER		STI 19	21 54 ⁻	DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	staff on appropri transfer methods	ed to train direct care ate non-weight bearing (moving from position y) for 1 of 2 sampled					
	nursing staff fail transfer needs (n movement from provide OT/PT (Therapy/Physica regards to her ac (bathing, dressin change of physica	o W210 as the facility's ed to assess/reassess the on-weight bearing position to position) and Occupational 1 Therapy) assessments in tivities of daily living, g, toileting) after the eal status and foot 12 sampled clients (client					
	failed to provide services: 1. To assess and information rece and provide staff method of transf clients (client A) to the client. 2. To ensure PT ordered for 1 of A). 3. To provide act for the use of PR medications when	ived from the hospital Ctraining in regards to a serring 1 of 2 sampled without causing injury OT was available as 2 sampled clients (client dequate documentation					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 38 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUII	LDING	00	COMPL	
		15G553	B. WIN			03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ABC OF	NORTHWEST IND	ANA INC. THE			TH AVE W LLVILLE, IN 46410		
				<u> </u>	LEVILLE, IN 464 IO		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	A).	ESC IDENTIFY THE INFORMATION)	+	IAG			DATE
	· ·	usiaian's ardars ara					
	4. To ensure physician's orders are carried out (push fluids) and documented						
	-	*					
	for 1 of 2 sampled clients (client A).						
	5 Dlanes - C. 4	W200 for the Co. 114 to					
	5. Please refer to W368 for the facility's						
		sampled clients (client					
	A), to ensure me						
	administered as	ordered.					
	This fodomal to a	ralatas ta aammilaint					
	This federal tag relates to complaint						
	#IN00122535.						
	This deficiency	was aited on 01/29/2012					
	-	was cited on 01/28/2013.					
	_	d to implement a					
		correction to prevent					
	recurrence.						
	0.2 ((-)						
	9-3-6(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 39 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	A. BUILDING B. WING			COMPL 03/15/	ETED
	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W000331		ICES provide clients with nursing dance with their needs.	WO	00331	Nursing services will be involve in developing systems for monitoring and training staff or following physician's order whe released from the hospital. Nursing services will train on the following: Transferring and transporting clients safely, medical signs and symptoms, reporting changes in client condition, and documenting the use of PRN medications. To ensure future compliance all nestaff will be trained on these topics and all staff will be retrained annually. The area manager will ensure that staff training records are up to date. An RN was contracted on 1/26/13 to conduct medication administration classes and was available for at time of Nursing Manager's absence if needed. The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, she took phone calls in the hospital just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to other staff and worked directly with the contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, an RN was hired as Director of Health Services. One LPN position remains	neen	04/12/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 40 of 61

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		15G553		LDING		03/15/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	Ь	
NAME OF P	PROVIDER OR SUPPLIEF	₹					
400.05	NODEL IMPORTANT	IANIA INIO TUE			ATH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					open with a temporary nurse filling		
					in until a suitable replacement can		
					be found. So at the present time,		
					The Arc Northwest Indiana employs	;	
					two RNs, two LPNs, and one temp		
					LPN.		
					All other homes were affected by		
					this dramatic change in nursing		
					staff. These new nurses will serve 5	54	
					th and our other group homes. In		
					addition an experienced RN will star	У	
					on staff until such time that these		
					new nurses are up to speed with all		
					of the clients care.		
					We now have a contract with a		
					temporary nursing agency so that		
					there is no delay in replacing a nurs	е	
					should one not be able to fulfill thei	ir	
					job duties.		
					In the absence of the Director of		
					Health Services, the Director of		
					Community Services was responsibl		
					for assuring policies and procedures		
					and nursing services. The Director of	of	
					Health Services is taking on this		
					responsibility and is responsible for		
					future monitoring of nursing		
					services.		
					When a consumer is hospitalized th	е	
					Community Services Nurse in		
					coordination with the Service		
					Coordinator will develop plans to		
					address any changes in condition. A		
					meeting will be held within 24 hour		
					prior to or following discharge with		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 41 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	of correction	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/15/2013
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	1921 54 MERRI	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Based on record review and interview, the facility failed to provide adequate nursing services: 1. To assess, verify medical information received from the hospital, provide sufficient staff, and provide staff training in regards to a method of transferring 1 of 2 sampled clients (client A) without causing injury to the client. 2. To ensure PT/OT (Physical/Occupational Therapy) were available as ordered for 1 of 2 sampled clients (client A). 3. To provide adequate documentation for the use of PRN (as needed) medications when new medications were ordered for 1 of 2 sampled clients (client A). 4. To ensure physician's orders were carried out (push fluids) and documented for 1 of 2 sampled clients (client A). Findings include:		the day program and others relevant to the client's care and document team discussion and approvals if necessary. To prevent reoccurrence this will be done for all consumers returning home after hospitalization as a standard practice. The Behavior Health Director or the Community Services Operations Director will hold a weekly meeting to review changes in client status and ensure these meetings are scheduled or have been completed and document this discussion.	e, n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 42 of 61

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN			03/15/	2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		13 at 2:15 PM a record					
	review of the BDDS (Bureau of Developmental Disabilities Services)						
		,					
	reports was completed and indicated the						
	following:						
	A RDDS raport	dated 02/26/13 indicated:					
		an appointment to see Dr					
	(doctor) [name], a neurologist at [hospital						
	name] due to physical change. Dr [name]						
	admitted [client A] to perform a series of						
	tests to determine a diagnosis. [Client A]						
		ospital. [Client A] seems					
	to be in fair cond						
		artion.					
	A BDDS report	dated 03/05/13 indicated:					
	•	ordinator (SC) called					
		[client A] is being					
		tatus update. The nurse					
	_	informed the Service					
	_	[client A's] diagnosis					
		ht toe fracture to the 2nd,					
		s. The nurse also					
	ĺ	C) that [client A's] right					
	foot has a mild f						
		"[Client A] does remain					
		this time. The nurse					
	_	treatment that the doctor					
		ce a boot on [client A's]					
	_	r her a mobilization					
	_	to walk and for the right					
		o heal on its own. An					
		s been initiated for					
	unknown origin.						
	""""" "" """ """"""""""""""""""""""""						ĺ

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 43 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			00	COMPL	
		15G553	A. BUII			03/15/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30, 10,	
NAME OF F	PROVIDER OR SUPPLIER				ITH AVE W		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFECT.)		DATE
	The Investigation	n East Chast Cummary					
	_	n Fact Sheet Summary of the 03/05/13 incident,					
		ndicated: "All staff at					
	Day Services (agency's own day program)						
	& (sic) all staff at group home reports no						
	abuse or aggression toward client. There						
	has been no report at Day Services that						
	injuries to client's (A's) foot were noticed,						
	however, staff noticed signs but it was						
	believed by staff that there were problems						
	with her left side per Developmental						
	Specialist who denies informing staff of						
	•	noticed injuries to					
		orted the problem to					
	_	ator & completed					
	incident report.	The problem with the left					
	foot & additiona	l limping occurred after					
	the client left hor	me the morning of					
	02/25/13, but bet	fore she returned home					
	from Day Servic	e on 02/25/13."					
	Conclusion: "It	is my belief that [client					
	A] sustained her	injuries at Day Service					
	on 02/25/13, hov	vever, the cause of the					
		T be determined. Staff					
	_	igns of injury to Health &					
		nanagement when					
		emonstrating signs of					
		to foot on 02/25/13."					
		ns: "Staff will be given					
		gnizing signs of injury.					
	The client pointed at foot and no one						
		ng was wrong. Client					
	sits most of day	at workshop."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 44 of 61

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G553	B. WIN	G		03/15/20)13
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			ITH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	The Incombinedia	1.4. 1.02/00/12					
		n dated 03/08/13					
	contained Interview Fact Sheets of statements taken of the staff who had						
	worked with client A. The dated						
	statements contained the following						
	information:						
	03/05/13: Day Service (DS) staff #2						
	wrote, "Most of February I noticed that						
	[client A] was wetting herself at least 3						
	times throughout the day. [Client A]						
	never use (sic) to do this. I was the main						
	` ,	r because she was most					
		e. The last day I saw					
		when she went on her					
	doctor's appoints	ment					
	03/06/13: DS st	aff #1 wrote, "Last time I					
		as about a week & half					
		't remember the exact					
	` / • `	problem I noticed, was					
		the bathroom more on					
		ported that to the Health					
	& (and) Safety 7	-					
		aff #1's addendum					
		taff (unidentified) said					
	1	as using the bathroom on					
		told [name] the Health &					
	I -	ne staff that work with					
	<u>-</u>	ed the peeing on self to					
		Tech. 2. The Health &					
	1	iced that she was not					
	1 -						
	using ner ien sic	le, and said that she is				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 45 of 61

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G553	B. WIN			03/15/	2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ITH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 ~ ~	service coord[inator] and					
	1	e wasn't using the left					
	side. No I did not tell a staff that						
	something was going on with her left						
	side. The Health & Safety Tech was the						
	one that noticed [client A] not using left						
	side4. The staff will notify the Health						
	& Safety Tech if there are changes in						
	behavior, or any injuries8. I don't know						
	who told staff about her left side. 9. I						
	oversee the group hab (habilitation), I						
	have four rooms I go between all day,						
	I -	I am not in one room all					
	1 -	etween four different					
		my responsibility to					
		do what they are suppost					
	(sic) to"						
	02/06/12: Heath	a & Safety Tech (HST)					
		• , ,					
		notice that [client A] was					
		ut was concern (sic) that					
		g on herself, which is not					
	[client A]"	Addandam indicated "					
		Addendum indicated, "					
	_	nator] said she has an					
		go to the doctor on					
		26/12) and [staff #3] ask					
		ipt (order) from the					
		(Urinary Tract Infection)					
		I was concern (sic). As					
		or writing an incident					
	_	nyself for not writing one.					
	` ′	to see if I can get the care					
	done for her righ	nt away. No one told me					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 46 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION		A. BUIL	DING	00	COMPLI	
		15G553	B. WINC			03/15/2	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ADC 05	NORTHWEST INDI	IANA INC. THE			TH AVE W LVILLE, IN 46410		
					LVILLE, IN 404 IU		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		as pointing at her feet"		1110			DATE
	mat [chefit A] w	as pointing at her reet					
	03/05/13: DS #/	wrote, "last time I					
	work (sic) with [client A] was Monday 02-25-13. Staff notice (sic) something						
		her. She didn't wanna					
	_	e bathroom. Staff ask					
		what was going on, she					
		some one said that she					
	_	using her left side. So					
	when I work with her I'll put her and (sic)						
	a wheelchair so we both wouldn't fall						
		een going on I think for 2					
		riced something was					
		er because she kept using					
		herself. Friday or					
		13 or 02/25/13) [client A]					
		ing (sic) her feet (sic)					
		there I saw that she was					
	_	socks was to to (sic). I					
		vas walking funny. [DS					
	` ′	nething was going on					
	_	e[client A] gets drop					
		c) up by home staff"					
	(Sie) and pien (bi	, of nome builting					
	03/06/13: Groun	Home (GH) staff #1					
	_	y morning (02/25/13) she					
		r workshop (day service),					
	` /	her normal unsteady gait					
	_	ed her up the staff at the					
	_	ht her out in a wheelchair					
		her up to walk to the					
		oing on her left foot.					
		ck to the group home I					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 47 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			onstruction on	(X3) DATE COMPL	
ANDILLAN	OI CORRECTION	15G553		LDING	00	03/15/	
		100000	B. WIN			03/13/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the house. I let her go to					
		nd she attempted to walk					
		first step. I helped her					
	_	own in a chair an took off					
		es. She sat and did not					
		ertime when I stood her					
	*	s she stepped on her left					
	_	n. I helped her up to the					
		he could eat then I called					
	the service coordinator to ask her if it had						
	been reported that she fell at the						
	workshop that morning and she said no.						
	She (SC) told me to do an incident report						
		nd that she would check					
	on it the next day	y with the workshop staff					
	and that [client A	A] had an appointment the					
	next day and she	would have the doctor					
	check her out. A	Also [client A] has fallen					
	once prior to this	s back in November.					
	When things hap	ppen at the workshop (day					
	service) there is	no communication					
	between the grou	up home and workshop as					
	to what happens	and what took place and					
	what the end rest	ult isDuring the week					
	when she is at ho	ome she rarely has any					
	accidents on hers	self except at night when					
	she is asleep at n	ight. Workshop staff					
	says that she has	an accident just about					
	everyday on hers	self. Wen I picked her up					
	at the workshop	on Feb. 25, 2013 the staff					
	that brought her	out said that [client A]					
	_	on herself and that she					
	kept grabbing at	her shoe. When I put her					
	to bed Monday n	night (02/25/13) her left					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 48 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	OING	00	COMPL	
		15G553	B. WING			03/15/	2013
NAME OF I	DDOWNED OD GUDDI IE	D		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIE	K		1921 54	ITH AVE W		
ARC OF	NORTHWEST INC	DIANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+			TAG	DEFICIENCY)		DATE
		e, but when we were at the					
	• •	13) and I was getting her					
		riced bruises on the bottom					
		nad them do an x-ray and					
	-	found it to be broken or					
		n her left foot. I honestly					
		ever happened it happened					
	_	On Monday night					
	` ′	n I put her to bed I looked					
		t appeared to be fine but					
		certain places like the ball					
		would snatch her foot					
	away from me.'						
		ed to call the nurse on					
		orm her of the falls, or					
	_	ge in status, from when she					
		rning of $02/25/13$, to when					
		from day service on					
	02/25/13 in the	PM.					
	03/06/13 Serv	ice Coordinator written					
		ated, "I contacted [HST].					
		I me that she has not been					
		any staff that [client A]					
		did state that when it's					
		tion, [client A] refuses to					
		f gets (sic) a wheelchair					
		to take her medication"					
	-	Addendum indicated, "The					
		ntment was made due to					
	* *	Wanted to get her					
		cause she was having					
		sing left hand & urinating					
		efusing to do anything.					
	on nersen and i	crusing to do anything.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 49 of 61

	ì '			ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G553	B. WIN	G		03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					TH AVE W		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ay Services wanted a UTI					
		[client A] kept urinating					
	1	rvice. [HST] was the					
		g the cup, but never did					
		octor's appointment.					
	There is no Incid	lent Report stating this					
	information."						
		ident Report dated					
	02/25/13 and tim	ned at 4:50 PM and 7:45					
	PM written by G	H staff #1 indicated,					
	"Client was limp	oing when I picked her up					
	from the worksh	op and when we got to					
	the group home,	she was not putting any					
	weight on her let	ft foot and fell when she					
	~	sterday evening." The					
		he questions, "What did					
		s Incident/Accident?"					
	1 *	te, "called the service					
		did an incident report."					
		not contact the nurse to					
		lls or client A's inability					
	to bear weight or						
	to bear weight of	n nei leit loot.					
	Client A's record	ls were reviewed on					
		8 AM. Client A's ISP					
		oort Plan) dated 01/14/13					
		s at risk for falls and had					
	_	The risk plan indicated,					
	"Contact the N						
		if unsure an injury has					
		ent A's record contained					
	the following da	ted documents:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 50 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN			03/15/2	2013
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			ITH AVE W _LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		llative Medical Record					
	indicated, "Adm	itted to [hospital]."					
	The Hospital Record contained the						
	_						
	following dated	documents.					
	02/26/13· X-Ra	y Report - Foot/complete					
	l '	ondisplaced fractures					
	_	ses of the second, third					
		arsals. There is mild					
		fracture fragments."					
	•	C					
	02/27/13: Histor	ry and Physical indicated,					
	"This is a patien	t I saw yesterday in my					
	office and sent to	o the emergency room					
	because the patie	ent's caregiver told me					
	that she was hav	ing some problems					
	getting up and w	valking. She was also					
	feeling somewha	at weak on the left side,					
	so she was admi	tted for further					
	evaluationThe	patient was admitted for					
		on and now the patient					
		ave left ankle fracture on					
		nkle, which was a					
	_	cture involving the base					
	of the second, th						
		ere is mild impaction of					
	•	ment also. The patient is					
	admitted for furt						
	_	ression: This is a					
	_	s several problems: 1. A					
		re. 2. Left-sided					
		uld be a stroke versus					
	cervical degener	rative joint disease related.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 51 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN	G		03/15/	2013
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
4D0.0F	NODEL WATER IND	IANIA INIC. THE			ITH AVE W		
	NORTHWEST IND	IANA INC, THE		MERKII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		n: My recommendation		0			5.112
	is to look at the	•					
		ging) of the brain and					
	_	nd then for the ankle					
	•	ent is going to be seen by					
	an orthopedic do						
	02/27/13: Podia	try Consult Note: "This					
		with non displaced					
	fractures of the l	eft footThe 2nd					
	metatarsal appears to be impacted at the						
	fracture site and	it is non displaced. It is					
	an unstable fract	ture but will do well					
	I	f the patient is non weight					
	bearing for 6-8 v	weeks.					
		valuation indicated client					
		n and weight bearing					
		veight bearing. The					
		ated follow-up PT was					
	-	ther Goal: To maintain					
		(Range of Motion of LEs ties). To assist in pt's					
	`	revent pressure ulcers					
	development"	_					
	ac relopinent						
	03/04/13: Rehal	bilitation					
		dmission Screening For					
		on: "History of Present					
		ted on 02/26/13 for					
		/A (Cerebrovascular					
	1 *	e). He referred the					
	, · ·	nergency room where she					
	_	oted to have right					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 52 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G553	B. WIN			03/15/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		1921 54	ITH AVE W		
	NORTHWEST IND	·			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	fullness leg erytl	hema (redness of the skin)					
	with some swelling but had neuro exam						
	was unremarkab	le. She had an x-ray of					
	that right (sic) fo	oot (left) area that					
	demonstrated so	me multiple fracture of					
		She was however					
		A (Transient Ischemic					
		blood flow to a part of the					
	/ \	CVAPatient was referred					
	/	litation evaluation and					
		ation management					
		ent was weak and not able					
	_						
		able to do activity of daily					
		ient does not meet rehab					
		ia. Discharge plan: home					
	1	e patient requires:					
		y, Occupational Therapy					
	and Speech The	rapy"					
	03/06/13: Disch	narge Summary: "Admit					
	date: 02/26/13.	Admitting Diagnosis:					
	Cellulitis. Disch	narge Diagnosis: Multiple					
	L (left) metatars	al (toe) fractures.					
	` ′	urse in Hospital With					
		f Any: Pt (patient) was					
	_	hopedic consultation					
		nmendations carried out.					
	1	legible] and now has					
	_	obilization device to her					
		l be dc (discharged) with					
	home health PT/	`					
		` •					
		ational Therapy) at home.					
		C to group home.					
	Discharged 03/0	6/13." Client A was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 53 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G553	B. WIN			03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIC. THE			ITH AVE W		
	NORTHWEST IND	IANA INC, THE		MERRIL	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	DE ICERCI)		DATE
	_	a prescription order from					
		ring PT/OT therapy. The					
	hospital faxed th	0 1					
		ch indicated, "will need					
		. Staff to transport at					
	6:00 PM."						
	02/06/12: 6	Jakina Madinal Don 1					
		alative Medical Record					
		narged from [hospital].					
	Returned to grou	ip home."					
	02/07/12: Cama	lative Medical Record					
		er (contract nurse) arrived					
		assess patientPain					
	· ·	lateral) (both) feetBoot					
	` ` `	t). Assist with transfers					
	`	Support Staff)N.O.					
	(New Order) for	PT/OT Therapy.					
	The QMRP (Qua	alified Montal					
		essional) was interviewed					
		· · · · · · · · · · · · · · · · · · ·					
		96 PM. The QMRP rse had seen client A in					
	ľ	y after she was discharged					
		l. She indicated the nurse					
		y instructions on how					
		nsfer (non weight bearing					
		nd care for client A and					
		ne indicated the hospital					
	I -	nation did not provide any					
		ransfers either. She					
		d been contacted by the					
		discharge and the					
	hospital indicate	d client A had fractures					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 54 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G553	B. WING		03/15/2013
NAME OF F	PROVIDER OR SUPPLIER	3	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				4TH AVE W	
ARC OF	NORTHWEST IND	IANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
TAG		and right sides and was	TAG		DATE
		ht. She indicated client A			
	ı	PT appointments upon			
		e nurse had not arranged			
	_	ndicated she received no			
	-	ons from anyone on how			
		be transferred, bathed or			
		developed a written			
		n a Two-Person Transfer			
		nair" after watching a			
		er by the agency training			
	department since				
	policy/procedure				
	policy/procedure	e existed.			
	An interview wi	th the RN (Registered			
		lucted on 03/13/13 at			
	· · · · · · · · · · · · · · · · · · ·	RN indicated staff should			
	have contacted t	he nurse when the client			
	arrived home on	02/25/13 when she was			
	limping. She fu	rther indicated there were			
		ents that night which			
		ted the staff to call the			
	nurse. She indic	cated staff were to contact			
	the nurse when t	the client has a change of			
		had a change of status			
		d home limping after day			
		ne fell twice, when she			
		weight on her foot and			
		her foot away when staff			
	_	RN indicated day service			
	should have repo	orted the problems with			
	-	de to the nurse as in could			
	indicate she mig	ht have a stroke. She			
	_	id not have to know what			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 55 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL	
ANDILAN	OF CORRECTION	15G553		LDING	00	03/15/	
		130333	B. WIN			03/13/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	the clients, they were to					
		hange. Day service and					
		f neglect to report those					
	_	N indicated the nurse who					
		he group home the day					
		charged failed to define					
	how staff were to	•					
		reight bearing) client A or					
		on how to transfer client					
	I	r fractures. There were					
		or staff regarding client					
	_	g bathing, toileting, bed					
		one place to another.					
		eted to ensure client A's					
		by obtaining PT/OT					
		I indicated based on the					
		ounding the facts on					
		A should have been seen					
		son on that day and not					
		heduled appointment the					
	•	rther indicated if there					
		ons in the hospital					
	_	ation from a verbal					
		the QMRP) then the					
	nurse should hav						
		where there were					
		eft, or on the left and					
	right feet.						
	An interview with	th the RN (Registered					
		ucted on 03/14/13 at					
	·	RN indicated client A					
		or OT/PT on 03/27/13 at					
	10:30 AM.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 56 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G553	B. WIN			03/15/2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL IMPORTANT	ANA INO THE			TH AVE W	
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEIGHNOT	DATE
	2 0 . 02/11/12	-4.4.50 DM1				
		at 4:50 PM a record				
		oup Home March 2012				
	`	on Administration				
	· ·	nt A, was completed and				
	included the follo	owing information:				
	02/07/12: 34: 11	action Change From				
		cation Change Form				
	indicated client					
		ers and one discontinued				
		The form indicated,				
		% Inhaler Solution. To				
		iliter) via nebulizer three				
		eeded. Contact nurse if				
		between a repeat dose.				
		ped and the RN's name				
		bottom. The form also				
	•	e fax a copy of the				
	revised MAR for	the nurse to review."				
		2013 MAR for client A				
		written order, "Albuterol				
		Solution - Inhale 3 ml via				
	nebulizer 3 times	s a day as needed -				
	03/07/13"					
		ot define the "as needed"				
	and what conditi	on/problems were to				
	exist before the i	medication should be				
	used.					
	An interview wit	th the RN (Registered				
	· /	ucted on 03/13/13 at				
	12:22 PM. The	RN indicated the MAR				
	should have cont	ained the specific				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 57 of 61

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COI	TE SURVEY MPLETED 15/2013
		196333	B. WING			13/2013
NAME OF I	PROVIDER OR SUPPLIEF	t .		ADDRESS, CITY, STATE, ZIP (CODE	
ABC OF	NODTHWEST IND	IANIA INIC THE		4TH AVE W LLVILLE, IN 46410		
	NORTHWEST IND	·		LLVILLE, IN 404 IU		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COL	RRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		when the PRN was to be				
		ated staff needed to be				
	directed for its n	eed and use by the RN.				
		cords were reviewed on				
	03/12/13 at 10:5	8 AM. Client A's record				
	contained the fol	llowing dated documents:				
	02/07/13: Cumu	ılative Medical Record				
	(notes regarding	client medical condition,				
	written by direct	care staff, nurse,				
	physician and an	ny medical providers)				
	1 1 2	ived report from day				
	· ·	ent A] urinated on herself				
	-	nes yesterday. U/A (urine				
		" The entry was signed				
	, ,					
	by LPN #2 on he	•				
		he next entry was dated				
		licated, "[Client A]				
	`	eurology) follow-up				
		ay. Rescheduled for				
	03/07/13."					
		from MD (Medical				
	,	alysis with C & S				
	(Culture & Sens	itivity) if indicated. Dx				
	(diagnosis) UTI	(Urinary Tract Infection).				
	02/12/13: Order	from client A's MD				
	indicated the lab	results (UA) was,				
	"Abnormal but r	not significant -				
		•				
		* ` '				
	Recommendatio if not on any flui	ns: Push p.o. (oral) fluids id restriction." Client A's idicate the nurse reviewed				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 58 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553	A. BUII B. WIN	LDING	00	COMPLETED 03/15/2013	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 1921 54	.DDRESS, CITY, STATE, ZIP CODE TH AVE W .LVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR this order or carr	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ied out this order. The no documentation by a		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	An interview with Nurse) was conditively was conditively was conditively and the office on moderate of the agency from the agency from This federal tag matter of the facility failed of the office of the o	his order. th the RN (Registered acted on 03/13/13 at RN indicated she was out medical leave from 4/13. She indicated sing service available to 02/13/13 to 02/19/13. The lates to complaint was cited on 01/28/2013.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 59 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIWI DDIG	00	COMPLETED
		15G553	A. BUILDING		03/15/2013
			B. WING		
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				4TH AVE W	
ARC OF	NORTHWEST IND	DIANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
W000368	483.460(k)(1)				
	DRUG ADMINIS	STRATION			
	The system for d	drug administration must			
	assure that all dr	rugs are administered in			
	compliance with	the physician's orders.			
	Based on record re	view and interview, the facility	W000368	The Community Service Nurse	e 04/12/2013
	failed for 1 of 2 sar	mpled clients (client A), to		will retrain the DSP's on how t	
	ensure PRN (as nee	eded) medication were		properly assess and administe	er
	administered as ord	dered by the physician and		PRN medications. To ensure	
	failed to ensure me	edication order changes were		further compliance the nurse v	vill
	implemented.			visit group home monthly for	
				three months and quarterly	
	Findings include:			thereafter. The monitoring erro	or
				was not assuring the medication	ons
	On 03/11/13 at 4:5	0 PM a record review of the		were discontinued. The chang	ge
	Group Home Marc	ch 2013 MAR (Medication		in procedure is that the DSPs	
	Administration Red	cord) for client A was		line through the remainder of t	:he
	completed and incl	luded the following information:		month for discontinued	
	•	C		medications and fax MAR to the	
	03/07/13: Medicat	tion Change Form indicated		nurse to assure it is done and	is
		ew medications orders and one		correct. The discontinued	
	discontinued medic	cation order. The form		medication will be brought in to	
	indicated, "Discont	tinue Calcium 600 mg		the Health Care clerk. The nu	
		it[amin] D 400 iu (international		will initial the faxed in MAR an	
	` • /	vice a day. The form was typed		give to the clerk. The clerk wi	
		was typed at the bottom. The		double check that both are	
		d, "Please fax a copy of the		completed. This document will	
		he nurse to review."		filed and held for three months	S TO
				ensure system is working.	
	03/2012: March 20	013 MAR for client A			
	contained a typed of	order for the Calcium. Under			
		dministration and hand written			
	was, "3-7-13 D/C ((discontinue)." The Calcium			
		ven on 03/07/13 - for two doses,			
		doses, 03/09/13 for two doses			
		ne dose. Six doses were			
		the 03/07/13 order to			
	discontinue the me				
	An interview with	the RN (Registered Nurse) was			
		3/13 at 12:22 PM. The RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet Page 60 of 61

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP: 03/15		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET A 1921 54	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.					
	This federal tag relates to complaint #IN00122535.					
	This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence.					
	9-3-6(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K12

Facility ID: 001067

If continuation sheet

Page 61 of 61